WellCare LLC
COVID-19 Specimen Intake Form

PATIENT DETAILS

Full Name: _____ **Age:** _____ **Date of Birth:** ____/____/_____
Address: _____
Primary Phone Number: _____-_____-_____ **Gender:** ◯ **Male** ◯ **Female**
E-mail (optional): _____

INSURANCE INFORMATION

Primary Insurance Name: _____
Subscriber ID: _____ **Group Reference:** _____
Secondary Insurance (if covered): _____
Subscriber ID: _____ **Group Reference:** _____
Primary Physician (optional): _____ **Ph. Number :** _____-_____-_____

CLINICAL DETAILS

Is the patient currently experiencing any of the following symptoms?
◯ Fever (>100.4ºF/37ºC) ◯ Cough ◯ Productive cough ◯ Shortness of breath ◯ No symptoms

UNDERLYING MEDICAL CONDITIONS

Asthma/chronic lung disease? ◯ Yes ◯ No
Diabetes/renal disease? ◯ Yes ◯ No
Heart or circulatory disease? ◯ Yes ◯ No
Cancer in the last 12 months? ◯ Yes ◯ No
Other (Specify): _____
_____
_____

Has the patient traveled from a location with endemic spread of COVID-19 within the last 14 days? ◯ Yes ◯ No
If yes, location: _____
Last date in country with endemic spread: _____

Has the patient had contact with a confirmed or suspect COVID-19 case within the last 14 days? ◯ Yes ◯ No

Has the patient had contact with anyone with an unexplained respiratory illness within the last 14 days? ◯ Yes ◯ No

PATIENT VITAL SIGNS

Temperature: _____ **Pulse:** _____ **Oxygen level:** _____
Clinician: _____ **Date:** _____

Submitting Physician's name, facility name and mailing address:

Dr. Hammad Rizvi, DO
90 Main Street
Hackensack, NJ 07601
Ph: 201-880-8112
NPI: 1659516227

Testing Location:
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